STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/7/18 through 11/9/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 315 certified bed facility was 228 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 3 closed record reviews .	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/07/18 through 11/09/18. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow. The census in this 315 certified bed facility was 228 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 3 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		12/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/14/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to protect the dignity of 2 of 38 residents in the survey sample (Resident # 85 and Resident #203). The findings included: 1. The facility failed to provide the dignity of Resident #85.	F 550	F550: RESIDENT RIGHTS 1. Corrective Action Resident #85□s care plan was noted to reflect resident□s desire to sit in room without being fully clothed. A blanket was provided for her to use to cover her extremities as desired. Resident #203 did not appear to be negatively affected by the deficient practice.	

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F 550	Continued From page 2 Resident #85 was admitted to the facility on 7/6/11 with the following diagnoses of, but not limited to high blood pressure, diabetes, anxiety disorder, depression and manic depression. On the quarterly MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 9/14/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #85 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing. On 11/8/18 at 10:40 am, the surveyor observed Resident #85 sitting in a chair beside of the resident's bed in her brief, no pants with only wearing a shirt. The surveyor observed this while the resident's roommate was having wound care performed. During this wound care observation, the surveyor observed the wound care nurse going to Resident #85's side of the room and speak to her. The surveyor observed 2 CNA's that went in and out of the resident's room prior to the wound care nurse performing wound care to the resident's roommate. The surveyor also observed 1 nurse during this time coming out of the resident's room. At 1:20 pm, the surveyor went into the resident's room and the resident was eating lunch. The surveyor again observed Resident #85 sitting in a chair while only I her brief, no pants and only a shirt on. The surveyor went to the nurses' station and the director of nursing (DON) to go with the surveyor to Resident #85's room. The DON and the surveyor went in to the resident's room. The resident was observed to be sitting in a chair with only her brief on, no pants and with only wearing	F 550	2. Identification of Deficient Practice Residents who prefer not to wear clothes when in their rooms or who received wound care without privacy have the potential to be affected. 3. Systemic Changes A) Staff on Moonlight Lane have been re-educated on ways to promote dignity for residents who prefer not to wear clothing while in their rooms. B) Wound Care Coordinator was educated on ensuring curtain is pulled completely to maintain dignity during dressing changes. 4. Monitoring A) Clinical Coordinator/Designee will conduct resident room rounds on residents who prefer to not wear clothes in their room to ensure dignity every week for 4 weeks, every other week for 4 weeks and every month for four months. B) Clinical Coordinator/designee will conduct treatment audits to ensure privacy curtain is pulled every week for 4 weeks, every other week for 4 weeks and every month for 4 months. C) Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing.	

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F 550	Continued From page 3	F 550		

a shirt. The DON asked the resident if she had taken her pants off and resident stated, "I don't know." There were no pants observed out in the room at this time. The DON and surveyor left the resident's room. The surveyor asked the DON if the appearance of the resident sitting in a brief, no pants on and only wearing a shirt acceptable to her. The DON replied, "No, it isn't. If the resident wanted not to wear her pants, then I would expect the staff to cover the resident with a sheet if she would allow it.
"

On 11/8/18 at 2:23 pm, the surveyor notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 11/9/18.

2. The facility staff failed to provide dignity during the wound care observation to Resident #203.

Resident #203 was admitted to the facility on 2/8/12 with the following diagnoses of, but not limited to high blood pressure, dementia, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/22/18, the resident was coded as having short term and long-term memory loss and being severely impaired in making daily decisions. Resident #203 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

On 11/8/18 at 10:40 am, the surveyor was observing wound care being performed on Resident #203 by the wound care nurse. The

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F 550	Continued From page 4 wound care nurse did not pull the curtain between the resident's bed and the door to the room. The resident is in the first bed and the closest to the door. The surveyor observed 2 CNA's (certified nursing assistant) that did open the door to Resident #203's room and stood at the door talking to the wound care nurse during the wound care observation. On 11/09/18 10:24 am, the surveyor interviewed the unit manager for the East Unit. The surveyor notified the unit manager of the above documented observations that were made on 11/8/18 with Resident #203. The unit manager stated that the staff should always pull the curtains between the residents and around the resident's bed so if someone entered the room from the hallway, they could not be seen by anyone in the hallway. The surveyor notified the administrative team on 11/9/18 at approximately 2:30 pm of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 11/9/18.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		12/24/18

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F 578	Continued From page 5 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure accurate DDNR's (durable do not resuscitate) orders for 1 of 39 Residents, Residents #73. The findings include:	F 578	F578: DDNR 1. Corrective Action Resident #73□s DDNR was completed on November 8, 2018. 2. Identification of Deficient Practice Residents with a signed DDNR on file have the potential to be affected.	

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F 578	Continued From page 6 For Resident #73, the facility staff failed to ensure the Residents DDNR was complete. Section's 1 and 2 had been left blank. The clinical record review revealed that Resident #73 had been admitted to the facility on 08/11/17 and readmitted on 04/26/18. Diagnoses included, but were not limited to, acute and chronic respiratory failure, dysphagia, chronic obstructive pulmonary disease, and muscle weakness. Section C (cognitive patterns) of the Resident's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/10/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The Resident's clinical record included a DDNR order form from the Virginia Department of Health. This form was dated 11/01/18 and read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." Neither box had been checked. Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank. This form had been signed by the Residents authorized representative. The administrator and the director of nursing	F 578	3. Systemic Changes A) All current signed DDNR□s on file were audited to ensure the forms were filled out correctly. B) All Social Workers were educated on proper procedure for completing DDNR forms. 4. Monitoring Social Worker will audit the DDNR during care plan meetings to ensure completion weekly x 6 months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Social Services.	

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F 578	Continued From page 7 were made aware of the above findings on 11/09/18 at 8:30 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 578		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		12/24/18

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F 656	Continued From page 8 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to develop a care plan for smoking for Resident #124. The clinical record of Resident #124 was reviewed 11/7/18 through 11/9/18. Resident #124 was admitted to the facility 9/29/18 with diagnoses that included but not limited to acute respiratory failure, asthma, end stage renal disease, dependence on renal dialysis, internal cardiac defibrillator, type 2 diabetes mellitus, insomnia, peripheral vascular disease, non-rheumatic mitral insufficiency, chronic osteomyelitis, gangrene, muscle weakness, lack of coordination, acute on chronic combined systolic and diastolic heart failure, major depressive disorder, hyperlipidemia, tachycardia, hypertension, and urinary tract infection. Resident #124's 30-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/27/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #124's current comprehensive care plan	F 656	F656: CARE PLAN 1. Corrective Action Resident #124□s was not negatively affected due to deficient practice. The resident was discharged on 12/6/18. 2. Identification of Deficient Practice Residents who begin smoking while in the facility have the potential to be affected. 3. Systemic Changes TRC Staff have been re-educated regarding the requirements for smoking assessments, corresponding care plans and protective smoking equipment required in order for residents to smoke. Clinical Coordinator/designee will complete an audit on all known smokers to ensure Smoking Assessment and care plan is in place. 4. Monitoring Clinical Coordinator/designee will complete an audit on all residents who smoke to ensure accurate care plan and smoking assessment are in place weekly x 4 weeks, every other week x 4 weeks and every month x 4 months.	

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F 656	Continued From page 9 initiated 10/10/18 and revised on 10/10/18 had the focus area of potential for respiratory status r/t (related to) recent respiratory failure, asthma. Interventions: Administer oxygen as ordered, encourage coughing and deep breathing, administer aerosol medication as ordered, observe for shortness of breath. The surveyor interviewed Resident #124 on 11/8/18 at 1:02 p.m. The resident was observed sitting at the front entrance, smoking. Resident #124 was observed with cigarettes and a lighter. The resident did not have any type of protective smoking equipment on. The surveyor reviewed Resident #124's clinical record and was unable to locate a smoking assessment upon admission to the facility. The nursing admission assessment dated 9/29/18 had been marked that Resident #124 was a non-smoker. The current comprehensive care plan dated 10/10/18 did not address Resident #124's smoking. The surveyor informed the assistant director of nursing (ADON) on 11/9/18 at 11:44 a.m. of the above concern. The ADON stated when Resident #124 was admitted, the resident was a non-smoker. The resident started hanging around with residents who were smokers and started smoking again. The ADON stated she was to blame. When asked if a smoking assessment should be done, the ADON stated yes and also placed on the care plan. The surveyor requested the facility policy on smoking on 11/9/18. The facility policy titled "Smoking/Vaping Policy"	F 656	Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing.	

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F 656	Continued From page 10 read in part "4. Care plans for residents who smoke will be developed to reflect interventions for safe smoking." The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the chief executive officer of the above concern on 11/8/18 at 2:16 p.m. No further information was provided prior to the exit conference on 11/9/18.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to provide incontinence care 1 of 39 Residents in the sample survey who were dependent on staff for Activities of Daily Living (ADL's), Resident #131. The Findings Included: The facility staff failed to provide incontinence care for Resident # 131. Resident #131 was admitted to the facility on 05/06/2014. Diagnoses included, but were not limited to, dementia, difficulty walking, cognitive communication deficit, epilepsy, abnormal posture, depression, and dysphagia.	F 677	F677: ADL CARE 1. Corrective Action Incontinence care was provided to Resident #131. 2. Identification of Deficient Practice Residents who are dependent on staff for incontinence care have the potential to be affected. 3. Systemic Changes Nightingale Lane Staff have been re-educated on providing incontinence care. 4. Monitoring Clinical Coordinator/Designee will conduct random resident room rounds to ensure incontinence care has been completed every week for 4 weeks, every other week for 4 weeks and every month for four	12/24/18

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F 677	Continued From page 11 Section C (cognitive patterns) of Resident # 131's most recent comprehensive MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/08/18 included a BIMS (brief interview for mental status) summary score of 01 out of a possible 15 points. Section G (functional status) had been coded to indicate total dependence with two persons physical assist (4/3) for transfer. Bed mobility and toilet use had been coded (3/3) for extensive assistance with two persons physical assist. Resident #131's comprehensive care plan included the focus areas: "ADLS (activities of daily living): Resident has a self-care deficit related to functionality and cognition related to diagnosis of dementia," has interventions that included but were not limited to, "Bathing/hygiene: She requires extensive assist of staff with bathing and hygiene." On 11/08/18 at 3:40 pm the surveyor observed a strong urine odor in Resident #131's room. On 11/08/18 4:15 pm the surveyor reentered Resident #131's room and again noted a strong urine odor. The surveyor requested CNA (certified nurse assistant) #1 to enter Resident #131 room with surveyor for observation. The surveyor asked CNA #1 if he noticed an issue. CNA #1 stated "it stinks". CNA #1 voiced he was waiting to change Resident #131 and give her a bath. CNA #1 voiced that he needed assistance in changing and bathing Resident #131. CNA #1 stated "There was an aide (CNA) off the floor transporting a Resident and the nurse (LPN) (licensed practical nurse) was giving meds and the other aide on the floor was providing care to another Resident. CNA #1 voiced he did not want	F 677	months to observe for instances pertaining to resident odors and incontinence. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

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F 677	Continued From page 12 to provide assistance to Resident #131 by himself, because of her broken leg. On 11/08/18 at 4:54 pm the surveyor spoke to LPN #1 and she voiced that there are three aids on the floor tonight one is in transport with Resident. LPN #1 stated "There are 28 Residents for 3 aids and one nurse and it is really hard to care for the Residents". The administrative team was made aware of the above findings on 11/09/18 at 9:10 am. No further information regarding this issue was provided to the survey team prior to the exit conference on 11/09/18.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician's orders for 2 of 38 residents (Resident #377 and Resident #378). The findings included: 1. The facility staff failed to obtain daily weights	F 684	F684: QUALITY OF CARE 1. Corrective Action Physician for Resident #377 and #378 was notified that daily weights were not obtained on the dates listed on November 8, 2018. 2. Identification of Deficient Practice Residents with physician ordered daily	12/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

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F 684	Continued From page 13 as ordered by the physician for Resident #377. The clinical record of Resident #377 was reviewed 11/7/18 through 11/9/18. Resident #377 was admitted to the facility 10/23/18 with diagnoses that included but not limited to critical illness myopathy, hypertension, hyperlipidemia, atherosclerotic heart disease, embolism and thrombosis of lower extremity arteries, chronic kidney disease, pleural effusion, major depressive disorder, Vitamin D deficiency, chronic systolic heart failure, hypothyroidism, paroxysmal atrial fibrillation, acute respiratory failure, acute hemorrhagic anemia, type 2 diabetes mellitus, transient ischemic attack, cerebral infarction, and encephalopathy. Resident #377's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/30/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #377's current comprehensive care plan initiated on 10/25/18 and revised 11/7/18 identified a focus area that read alteration in cardiovascular status r/t (related to) critical illness, myopathy, HTN (hypertension), HLD (hyperlipidemia), CAD (coronary artery disease), recent MI (myocardial infarction), recent DVT (deep vein thrombosis), CHF (congestive heart failure), A-Fib (atrial fibrillation). Interventions: Daily weight. Notify MD (medical doctor) of 3 lb (pound) weight gain in one day or 5 lb weight gain in one week. The October and November 2018 physician's orders were reviewed. The physician ordered daily weights on 10/30/18 to start on 10/31/18	F 684	weights have the potential to be affected. 3. Systemic Changes Clinical Coordinator/designee will complete 100% audit of residents with daily weights to ensure physician□s orders were followed. TRC Staff have been re-educated regarding obtaining residents□ daily weights per physician order. 4. Monitoring Clinical Coordinator/Designee will audit physician ordered daily weights every week for 4 weeks, every other week for 4 weeks and every month for four months to ensure compliance. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 14	F 684		

with the following orders to notify MD of a 3 lb weight gain in 24 hours or 5 lbs in 1 week.

The surveyor reviewed the October 2018 and the November 2018 electronic medication administration records (eMARS) and the electronic treatment administration records (eTARs). There were no recorded daily weights on either.

The surveyor reviewed the October 2018 and November 2018 Weights and Vitals Summary. The weights were as follows:
11/1/18=162.5
11/7/18=162
11/8/18=158.5
11/9/18=159.5

Daily weights were not obtained on 10/31/18, 11/2/18, 11/3/18, 11/4/18, 11/5/18, or 11/6/18. The staff failed to obtain daily weights on 6 days in October 2018 and November 2018.

The surveyor reviewed the October 2018 and November 2018 progress notes and found no daily weights documented.

The surveyor informed the assistant director of nursing of the above concern on 11/9/18 at 2:08 p.m. The ADON provided the paper record for weights for the week of October 28-November 3 and the weight record for the week of November 4 through November 10. There were no record weights for Resident #377 on the week of October 28-November 3 and only three (3) weights (Wednesday 11/7/18, Thursday 11/8/18, and Friday 11/9/18) recorded on the weight record for November 4 through November 10.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15	F 684		

The surveyor informed the administrative staff of the above concern prior to the exit conference on 11/9/18.

No further information was provided prior to the exit conference on 11/9/18.

2. The facility staff failed to obtain daily weights as ordered for Resident #378.

The clinical record of Resident #378 was reviewed 11/7/18 through 11/9/18. Resident #378 was admitted to the facility 10/25/18 with diagnoses that included but not limited to nonrheumatic aortic valve disorders, type 2 diabetes mellitus, presence of a prosthetic heart valve, hypertension, hyperlipidemia, hypothyroidism, acute kidney failure, benign neoplasm of heart, atrial fibrillation, Vitamin D deficiency, gastroesophageal reflux disease, and major depressive disorder.

An admission minimum data set (MDS) had not yet been completed. Initial care plan initiated on 10/29/18 identified the resident to be at nutritional risk due to history of heart attack, diabetes, high blood pressure, and hypothyroidism. Initial weight loss anticipated due to swelling/edema present on admission. Interventions: Weights per MD (medical doctor) order.

Resident #378's October 2018/November 2018 physician orders read in part "Daily weight-call MD of increase of 2 lbs (pounds) or greater on 2 consecutive days or 4 lbs or more in 1 week active order date 10/25/18."

The surveyor reviewed the October 2018 and the November 2018 electronic medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16 administration records (eMARS) and the electronic treatment administration records (eTARs). There were no recorded daily weights on either. The surveyor reviewed the October and November 2018 Weights and Vitals Summary. The weights were as follows: 10/27/18=190.7 11/1/18=183.5 11/7/18=177.6 Daily weights were not obtained on 10/26/18, 10/28/18, 10/29/18, 10/30/18, 10/31/18, 11/2/18, 11/3/18, 11/4/18, 11/5/18, or 11/6/18. The staff failed to obtain daily weights on 5 days in October 2018 and 5 days in November 2018. The surveyor reviewed the October 2018 and November 2018 progress notes and found no daily weights documented. The surveyor informed the assistant director of nursing of the above concern on 11/9/18 at 2:08 p.m. The ADON provided the paper record for weights for the week of October 28-November 3 and the weight record for the week of November 4 through November 10. There were no record weights for Resident #378 for the week of October 28-November 3 or for November 4 through November 10. The surveyor informed the administrative staff of the above concern prior to the exit conference on 11/9/18. No further information was provided prior to the exit conference on 11/9/18.	F 684		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		12/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686 SS=D	Continued From page 17 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide the necessary care and services for 3 of 38 residents (Resident #377, Resident #173, and Resident #203) with pressure ulcers. The findings included: 1. The facility staff failed to follow the physician's orders for the care of Resident #377's pressure ulcers. The clinical record of Resident #377 was reviewed 11/7/18 through 11/9/18. Resident #377 was admitted to the facility 10/23/18 with diagnoses that included but not limited to critical illness myopathy, hypertension, hyperlipidemia, atherosclerotic heart disease, embolism and thrombosis of lower extremity arteries, chronic kidney disease, pleural effusion, major	F 686	F686: PRESSURE ULCER 1. Corrective Action Resident #377, #203 and # 173 did not appear to be negatively affected by deficient practice. Residents□ physicians were notified on November 9, 2018. 2. Identification of Deficient Practice Residents requiring wound cleansing and dressing changes have the potential to be affected. 3. Systemic Changes A) The Wound/Dressing Change and Infection Control Policies were reviewed. B) Wound Care Coordinator has been re-educated regarding proper wound care treatment procedure. 4. Monitoring Staff Development Coordinator/Designee will conduct random wound care treatment audits every week for 4 weeks, every other week for 4 weeks and every	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

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F 686	Continued From page 18 depressive disorder, Vitamin D deficiency, chronic systolic heart failure, hypothyroidism, paroxysmal atrial fibrillation, acute respiratory failure, acute hemorrhagic anemia, type 2 diabetes mellitus, transient ischemic attack, cerebral infarction, and encephalopathy. Resident #377's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/30/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section M Skin Conditions identified the resident was at risk for the development of pressure ulcers and was assessed with two unstageable pressure areas. Resident #377's current comprehensive care plan identified Resident #377 to have potential for/impaired skin integrity r/t (related to) atherosclerotic heart disease, hyperlipidemia, ASA therapy, neuropathy, O2 (oxygen) dependent. CHF (congestive heart failure), muscle weakness, Vit (Vitamin) D deficiency, depression, thrombosis of the lower extremity, CKD3 (chronic kidney disease-stage 3), hypothyroidism, A fib (atrial fibrillation), DM (diabetes mellitus)-10/23/18 Right heel unstageable, unstageable to the sacrum, right buttock stage 2 =resolved 11/6/18. Interventions: Administer treatments as ordered. The surveyor reviewed Resident #377's October 2018/November 2018 physician's orders for wound care. Cleanse sacrum unstageable wound with NS (normal saline) and pat dry. Apply skin prep to surrounding peri wound skin and allow to dry. Apply silver alginate and a optifoam 4 x 4 dressing bid (twice a day). Start date: 11/6/18. Silvadene cream 1% Apply to right heel	F 686	month for four months to ensure compliance. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 19	F 686		

topically every day for right heel unstageable. Cleanse right heel with NS and pat dry. Apply silvadene and dry dressing daily-wound healing. Start date: 11/7/18.

The surveyor observed wound care on 11/9/18 at 9:11 a.m. with licensed practical nurse #2. L.P.N. #2 knocked on door, checked the resident's pain level. L.P.N. #2 washed hands and then cleaned the over the bed table with Sani-Cloths. L.P.N. #2 placed a barrier on the table and washed hands. Gloves were donned. L.P.N. #2 dated bandage prior to applying. Removed gloves and left room to get treatment cart. L.P.N. #2 brought treatment cart into resident's room. L.P.N. #2 removed sterile water and gauze from the treatment cart and placed them on the barrier. Gloves on. Cleaned scissors with Sani-cloth but not the lanyard and placed both the scissors and the lanyard on the barrier. Locked cart. Removed gloves. L.P.N. #2 dated sterile water, washed hands, and donned gloves. The head of bed was lowered. Resident #377 was turned on left side. Right heel sock removed and placed on bed. Old dressing removed and discarded. L.P.N. #2 removed gloves and washed hands. L.P.N. #2 donned gloves. Right heel has quarter size unstageable dark area-eschar. Area cleaned with sterile water numerous times. L.P.N. #2 removed gloves and hands were washed. L.P.N. #2 donned gloves. Silvadene cream applied to area and wrapped with kerlix. Dated tape applied. L.P.N. #2 removed gloves and washed hands. Donned gloves then took gloves off. L.P.N. #2 went to treatment cart and got a bottle of Normal Saline. L.P.N. #2 donned gloves. The unstageable pressure area on sacrum is elongated and approximately 2 and 1/2 inches by 1 inch and a second one approximately nickel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 20	F 686		

size. L.P.N. #2 cleaned both areas at the same time with normal saline gauze. L.P.N. #2 did not use a circular fashion starting from the center of the area and working outwards. L.P.N. #2 applied skin prep to perimeter of wound, then silver alginate and optifoam dressing was applied. L.P.N. #2 removed gloves and washed hands. Donned a new pair of gloves. L.P.N. #2 cleaned the area surrounding the wound with foam cleanser. L.P.N. #2 removed gloves and washed hands. L.P.N. #2 donned new gloves. Greer's goo applied to area that was reddened. L.P.N. #2 removed gloves and washed hands. L.P.N. #2 donned gloves and repositioned the resident. Green heel boot applied to right leg. All supplies removed and discarded. Table cleaned with Sani-cloth and scissors cleaned with Sani=Cloth. Trash removed.

The order for wound care to the right heel read to use normal saline. L.P.N. #2 did not follow the physician order. Sterile water was used. L.P.N. #2 did not use circular motion to cleanse the wound from the center of the wound outward.

The surveyor informed the director of nursing of the above concern on 11/09/18 1:27 p.m. and requested the facility policy on wound care.

The surveyor reviewed the facility policy for wound care titled "Wound Cleansing and Dressing Changes" on 11/9/18. The policy read in part "10. Gently cleanse the wound with normal saline (unless order specifies differently) starting in the center of the wound and working outward in a circular motion. Ensure that you clean any areas of tunneling or undermining and wound edges. Repeat with another clean gauze as needed until the entire wound surface is cleaned."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21	F 686		

No further information was provided prior to the exit conference on 11/9/18.

2. The facility staff failed to clean Resident #173's pressure ulcers per professional standards to promote healing.

The clinical record of Resident #173 was reviewed 11/7/18 through 11/9/18. Resident #173 was admitted to the facility 10/8/18 with diagnoses that included but not limited to left femur fracture, dysphagia, ventricular tachycardia, urine retention, atherosclerotic heart disease, hypothyroidism, irritable bowel syndrome, benign prostatic hyperplasia (BPH), hypertension, atrial fibrillation, insomnia, constipation, and Vitamin D deficiency.

Resident #173's 14-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/22/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section M Skin Conditions assessed the resident to be at risk for the development of pressure ulcers and the resident was assessed with two unstageable deep tissue injuries.

Resident #173's current comprehensive care plan had the focus area of pressure ulcer/impaired skin integrity. 10/15/18 DTI (deep tissue injury) wound to left great toe and left heel (10/15/18). Intervention: Bed cradle, provide treatments as ordered, float heels as tolerated while in bed.

The October 2018/November 2018 physician's orders were reviewed. Resident #173's had orders to apply skin prep to bilateral heels and tip of left great toe every shift for unstageable DTIs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22	F 686		

The surveyor interviewed Resident #173 on 11/8/18 at 11:44 a.m. The resident gave permission for the surveyor to observe wound care.

The surveyor observed wound care on 11/9/18 at 10:12 a.m. with licensed practical nurse #2. L.P.N. #2 knocked on door and supplies placed on table. L.P.N. #2 cleaned the nightstand with sani-cloth and placed a barrier on the nightstand. L.P.N. #2 washed and donned gloves. L.P.N. #2 cleaned the tip of Resident #173's left great toe with normal saline repeatedly. Removed gloves and washed hands. Resident #173 has a dark area on tip of toe-unstageable deep tissue injury. L.P.N. #2 donned gloves and applied skin prep to the tip of the left great toe. L.P.N. #2 applied the skin prep repeatedly. Removed gloves and washed hands. Donned clean gloves and cleaned the two (2) areas on Resident #173's left heel with normal saline. L.P.N. #2 cleaned the larger pressure area first then, with the same gauze, cleaned the smaller pressure ulcer. L.P.N. #2 removed the gloves and washed hands. Skin prep applied to the larger pressure ulcer first then to the smaller pressure ulcer and then back again to the larger. L.P.N. #2 removed the gloves and washed hands. L.P.N. #2 placed the heel bow on the left foot.

L.P.N. #2 did not follow the physician order when normal saline was used to clean the left great toe and the left heels. The physician order read to apply skin prep to bilateral heels and the tip of the left great toe bid. L.P.N. #2 did not clean in a circular motion the areas on the left great toe and the left heel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 23	F 686		

The surveyor informed the director of nursing of concerns with wound care on 11/9/18 at 1:27 p.m. and requested the facility policy on wound care.

The surveyor reviewed the facility policy for wound care titled "Wound Cleansing and Dressing Changes" on 11/9/18. The policy read in part "10. Gently cleanse the wound with normal saline (unless order specifies differently) starting in the center of the wound and working outward in a circular motion. Ensure that you clean any areas of tunneling or undermining and wound edges. Repeat with another clean gauze as needed until the entire wound surface is cleaned."

No further information was provided prior to the exit conference on 11/9/18.

3. The wound care nurse performed wound care to Resident #203. During the wound care observation, the wound care nurse cleaned her scissors but did not clean the lanyard that was attached to the scissors and cleaned the sacral wound with 4x4's but did not use a circular motion in cleaning of this wound.

Resident #203 was admitted to the facility on 2/8/12 with the following diagnoses of, but not limited to high blood pressure, dementia, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/22/18, the resident was coded as having short term and long-term memory loss and being severely impaired in making daily decisions. Resident #203 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 24	F 686		

On 11/8/18 at 10:40 am, the surveyor was observing wound care being performed on Resident #203 by the wound care nurse. During this observation, the surveyor noted the surveyor noted the following that the wound care nurse performed:

The wound care nurse prepared her work area on the resident's bedside table. The table was cleaned with a disinfectant wipe and then a drape was placed on it. The nurse laid the clean supplies that would be used for the wound care on the drape. The wound care nurse cleaned her scissors but the lanyard that was attached to the scissors was not cleaned. The nurse laid the scissors with the lanyard attached on the clean drape beside of the clean supplies that the nurse would use for the wound care to the resident. The resident had 2 open areas on the outer aspect of the right foot that the physician ordered them to have skin prep applied and then wrapped with Kerlix. The wound care nurse cleaned these areas with normal saline that was applied to clean 4x4's. The wound care nurse used the same 4x4's to clean both open areas to the outer aspect of the right foot. The nurse cleaned the opens areas using a circular motion but went back over the open areas again with using the same 4x4. While the wound care nurse waited for the skin prep to dry on these areas, the nurse blew on the areas so that drying could be faster. The wound care nurse completed the wound care to the outer aspect of the right foot. The wound care nurse then removed her gloves and washed her hands. The nurse reapplied gloves and removed the old dressing that was on the resident's sacrum area. The nurse removed her gloves and washed her hands. The wound care nurse reapplied clean

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 25 gloves to her hands. The nurse began to clean the sacral wound with normal saline that had been applied to clean 4x4's. The wound care nurse began cleaning the wound by wiping the 4x4's over the wound and continued to clean the wound by wiping all areas of the wound but not in a circular motion. The nurse continued wound care to the sacral wound as prescribed by the physician. On 11/8/18 at approximately 1 pm, the surveyor requested and received a copy of the policy titled, "Wound Cleansing and Dressing Changes". It read in part, " ...10. Gently cleanse the wound with normal saline (unless order specifies differently), starting in the center of the wound and working outward in a circular motion ...Repeat with another clean gauze as needed until the entire wound surface is cleaned ..." The surveyor notified the administrative team of the above documented findings on 11/9/18 at approximately 2 pm. No further information was provided to the surveyor prior to the exit conference on 11/9/18.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		12/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26 by: Based on, clinical record review, staff interview, and over the course of a complaint investigation, the facility staff failed to ensure that 3 of 39 Residents in the survey sample received adequate supervision and assistance to prevent accidents, Resident # 131, Resident #48, and Resident #124. The findings included: 1. The facility staff failed to transfer Resident #131 properly using two staff to operate Hoyer Lift as determined necessary by the comprehensive plan of care, and facility policy on 10/20/18 where the documentation described the injury as a skin tear. Subsequently on 10/24/18, documentation reflected that Resident #131 sustained a fracture of the right leg during an improper transfer from the wheelchair to the bed where the fracture was described as " likely caused by CNA #1's improper lift transfer and her failure to ensure the Resident's lower extremities were properly supported and aligned during the transfer ...." CNA #1 stated "I am very upset and I don't understand why I was the only one investigated because others transferred her and I know the fracture was not obtained when I transferred Resident #131, but I take full responsibility for the skin tear". Resident #131 was admitted to the facility on 05/06/2014. Diagnoses included, but were not limited to, dementia, difficulty walking, cognitive communication deficit, epilepsy, abnormal posture, depression, and dysphagia. Section C (cognitive patterns) of Resident # 131's most recent comprehensive MDS (minimum data	F 689	F689: FREE OF ACCIDENTS/HAZARDS Section 1 1. Corrective Action Resident□s #131 will be provided adequate supervision and assistance to prevent accidents. 2. Identification of Deficient Practice Residents requiring supervision and assistance have the potential to be affected. 3. Systemic Changes A) Staff members who improperly transferred resident□s #131 were counseled and educated. B) Clinical team members were educated on the Resident Handling Policy and Procedure. C) Clinical team members participated in a return demonstration for utilizing resident lifts. D) Education upon orientation and annually has been modified to include return demonstrations, in addition to verbal instruction. E) Clinical Coordinator/Designee will conduct audits of resident transfers by clinical team members every week for 4 weeks, every other week for 4 weeks and every month for four months to ensure compliance. 4. Monitoring Clinical Coordinator/Designee will conduct random audits of resident transfers by clinical team members every week for 4 weeks, every other week for 4 weeks and every month for four months to ensure compliance. Results of the observations will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27 set) assessment with an ARD (assessment reference date) of 10/08/18 included a BIMS (brief interview for mental status) summary score of 01 out of a possible 15 points. Section G (functional status) had been coded to indicate total dependence with two persons physical assist (4/3) for transfer. Dressing and eating had been coded (3/2) for extensive assistance with one person physical assist. Bed mobility and toilet use had been coded (3/3) for extensive assistance with two persons physical assist. Locomotion on unit and personal hygiene had been coded to indicate total dependence with one person physical assist (4/2). Locomotion off unit was coded (7/2) indicating activity occurred only once or twice with one person physical assist. The MDS had been coded to indicate the Resident used a wheelchair for a mobility device. Resident #131's comprehensive care plan included the focus areas: "ADLS (activities of daily living): Resident has a self-care deficit related to functionality and cognition related to diagnosis of dementia," has interventions that included but were not limited to, "Resident requires extensive assist /2person assist with transfers-FBL (full body lift)." LPN (licensed practical nurse) #1 nursing note dated 10/20/18 documented the following under progress notes: "Resident was being transferred from her bed to wheelchair via Hoyer lift when her right leg hit metal on her wheelchair and she obtained a skin tear. Resident was transferred back to bed, pressure applied to wound, and first aid. MD (medical doctor) notified via telephone and POA (power of attorney) notified to call facility. New order: clean skin tear right shin ....VS (vital signs) 136/78, 98% o2 (oxygen) saturation,	F 689	reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing. Section 2 1. Corrective Action Resident #124□s was not negatively affected due to deficient practice. The resident was discharged on 12/6/18. 2. Identification of Deficient Practice Residents who begin smoking while in the facility have the potential to be affected. 3. Systemic Changes A) TRC Staff have been re-educated regarding the requirements for smoking assessments, corresponding care plans and protective smoking equipment required in order for residents to smoke. 4. Monitoring Clinical Coordinator/designee will complete an audit on all residents who smoke to ensure accurate care plan and smoking assessment are in place weekly x 4 weeks, every other week x 4 weeks and every month x 4 months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing. Section 3 1. Corrective Action Resident #48 had an updated elopement assessment and care plan review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28 98.9 temperature, respirations 18. Nursing intervention to place cover to wheelchair metal with foam to protect Resident ...will continue to observe." LPN #2 nursing note dated 10/24/18 at 1736 read in part: "Resident's right leg observed to be bruised and significantly swollen. Resident c/o (complains of) mild pain when touching the right ankle area, when elevated and not moved Resident's pain is relieved. NP (nurse practitioner) notified, right ankle and right tib/fib (tibia and fibula) (lower leg bones above ankle) x-ray ordered. Will continue to observe." Nurse practitioner physician note dated 10/24/18 at 1715 read in part: "Resident presented with bone pain. It is described as acute. The symptom is sudden in onset and ongoing. The complaint moderately limits activities. Mechanism of injury includes unknown. The symptom is exacerbated by activity. Nursing reports RLE (right lower extremity) swelling after an alleged injury over the weekend. Asking for Evaluation ....Right lower extremity inspection (lower leg): deformity and swelling; inspection-ankle: swelling at lateral malleolus (bony prominence of outer ankle) ...." LPN #1 nursing note dated 10/24/18 at 2207 read in part: Results received from right ankle x-ray. Impression read and scanned to doctor. Acute fracture of distal right tibia and fibula. New order: Resident to be sent to ED (emergency department) for evaluation and treatment of RLE (right lower extremity fractures) ...." The surveyor reviewed clinical record on 11/09/18 and observed a radiology report dated 10/24/18 for right tibia and fibula x-ray. Impression read in	F 689	completed on November 8, 2018. Resident #48 was not adversely affected due to the deficient practice. 2. Identification of Deficient Practice Residents who require a transfer from a secured to an unsecured unit have the potential to be affected. 3. Systemic Changes A) Policy and Procedure was developed to assess/determine when a resident no longer requires a secured unit. B) Clinical Coordinators/Social Workers were educated on Secured Unit Transfer policy C) Social Worker/Designee will conduct an audit on all residents who were transferred from the secured unit to ensure policy was followed weekly x 4 weeks, every other week x 4 weeks and monthly x 4 months. 4. Monitoring Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29	F 689		

part: "Acute fractures of the distal right tibia and fibula as discussed."

The surveyor interviewed LPN #1 on 11/07/18 1518. The surveyor asked LPN #1 what happened on 10/20/18 when Resident #131 sustained an injury to her right leg. LPN #1 voiced she was on lunch at the time the incident occurred. LPN #1 was paged to come back to unit. When LPN #1 arrived on unit, the weekend nurse supervisor was placing a dressing on Resident #131's skin tear. The bleeding was described as "bad". Bruising behind skin tear about 2x2 inches in diameter was observed on the outside calf area above Resident #131's ankle. LPN #1 reported to surveyor that injury was related to transfer. LPN #1 reported to surveyor that at the time of the incident the Resident #131 was presenting with no pain of that extremity with or without ROM (range of motion), and no swelling. This presentation preceded to the next day as well because LPN #1 voiced she worked the following day.

The surveyor interviewed DON (director of nursing) on 11/07/18 at 1540. The surveyor asked DON what happened on 10/20/18 when Resident #131 sustained an injury to her right leg. DON voiced that incident occurred when CNA #1 (certified nurse assistant) attempted to transfer Resident via full body lift by herself and CNA #1 lowered Resident into wheelchair lop sided. CNA #1 tried to readjust Resident in wheelchair and was unsuccessful. DON stated the only injury noted at the time of incident was a skin tear. The plan of correction that was implemented was one on one reviewing of the policy titled "Resident Handling Program" between DON and CNA #1. DON voiced hands on training was not performed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30	F 689		

because "technique wasn't an issue". DON was unsure at this time if issue was brought to QA (quality assurance) team yet, but voiced that a QAPI (Quality Assurance and Performance Improvement) team meeting will be at the end of November. The surveyor requested investigation documentation and a copy of the policy and procedure that was reviewed at this time.

The surveyor interviewed CNA #1 on 11/07/18 at 1545. The surveyor asked CNA #1 what happened on 10/20/18 when Resident #131 sustained an injury to her right leg. CNA #1 stated to surveyor that Resident #131 requires a full body lift to transfer and she took it upon herself to transfer Resident #131 by herself. CNA #1 reported to surveyor that no nurse or supervisor was on the unit and no one could help CNA #1 when she requested help with the transfer. The surveyor asked CNA #1 to describe the transfer in question that allegedly caused Resident #131's injuries. CNA #1 stated she raised the bed up to waist level and used remote to raise Resident #131 up, after Resident was raised up, "I pulled the lift out and pulled her off the bed and the lift was facing wheelchair. I turned her around. Her back was facing wheel chair. I lowered her into the wheelchair and I noticed Resident #131 was lopsided and I asked for help at that point." CNA #1 voiced that Resident #131's legs were touching the bed during the transfer as she was pulling lift out from bed to move Resident to wheelchair. Another nurse assisted CNA #1 in readjusting Resident #131 in wheelchair and noticed the a skin tear on Resident #131's right leg. CNA #1 stated "I got a towel and held it on the wound". CNA #1 reported the weekend nurse supervisor was alerted by another nurse to come check Resident #131. The weekend nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 31	F 689		

supervisor checked Resident did ROM to leg and determined it was just a skin tear. The weekend nurse supervisor then dressed the wound. CNA #1 stated staff does not use the lift to transfer Resident #131, "they just arm and arm her". CNA #1 voiced she did not want to get Resident #131 up that way and harm her. CNA #1 voiced she felt pressured to get Resident #131 up, "she had to be up that afternoon because she was a feeder and this was around lunch". CNA #1 stated she noticed no changes or discoloration to Resident #131's right leg the following day, "When I left that day her foot was fine and I worked 7-3pm. Monday and Tuesday off. I came back Wednesday and worked with a different group of Residents and somebody got Resident #131 up with the lift that day and they called for an x-ray that night". CNA #1 verbalized that Resident #131 will respond to pain by screaming. CNA #1 voiced she knows Resident #131's fracture was not related to the transfer in question. CNA #1 stated "I am very upset and I don't understand why I was the only one investigated because others transferred her and I know the fracture was not obtained when I transferred Resident #131, but I take full responsibility for the skin tear".

The surveyor interviewed CNA #2 on 11/08/18 at 0839. The surveyor asked CNA #2 what happened on 10/20/18 when Resident #131 sustained an injury to her right leg. CNA #2 voiced she was working the day the incident occurred. CNA #2 stated "I came back from lunch CNA #3 was outside Resident 131's door asking for a nurse and I went to get the supervisor. I came back with weekend nurse supervisor. I was at the door way saw blood on the floor and Resident 131's leg with the skin laid open.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32	F 689		

Resident #131 was in her wheelchair". The surveyor asked CNA #2 if she ever assist in transferring Resident #131. CNA #2 stated "she is not my patient, but I help transfer her often". CNA #2 reported to the surveyor that she helped transfer Resident #131 the day she was sent to the ER (emergency room). "CNA #4 helped me transfer. I used the lift and held her right leg while she was transferred back to bed. I noticed something was not right with her foot and that's why I supported her foot. It looked like it was displaced, not in the normal position. LPN #2 was notified and Resident #131was sent to the ER." The surveyor asked CNA #2 if Resident is transferred any other way than a full body lift. CNA #2 stated "Resident #131 is always transferred with the lift".

The surveyor interviewed CNA #3 on 11/08/18 at 1213. The surveyor asked CNA #3 what happened on 10/20/18 when Resident #131 sustained an injury to her right leg. "CNA #1 came and got me when Resident #131 obtained her skin tear. I saw blood on her leg. It was just a skin tear, no bruising, nothing, and a bruise that was already there prior to the transfer. I asked CNA #2 to get a nurse. I don't work with Resident #131 and I don't assist with her care unless asked. I was not there during the transfer."

The surveyor interviewed the weekend nurse supervisor via telephone on 11/08/18 at 1357. The surveyor asked weekend nurse supervisor what happened on 10/20/18 when Resident #131 sustained an injury to her right leg. "CNA #2 came and got me. Resident #131 was sitting in her wheelchair, bleeding, there was a skin tear. I got some gauze and started treating the skin tear. LPN #1 came while I was cleaning the skin tear.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33	F 689		

CNA #3 voiced Resident #131's leg was bumped on wheelchair leg rest." Weekend nurse supervisor reported to surveyor "the only injury was the skin tear".

The surveyor interviewed CNA#4 via telephone on 11/08/18 at 1416. The surveyor asked CNA #4 what happened on 10/20/18 when Resident #131 sustained an injury to her right leg. "I was off that weekend. I was working when Resident #131 was sent out. Resident #131 was transferred from chair to the bed using the lift. Her leg looked like it was broken. When we put her back in the bed her leg was like spaghetti and mushy like." CNA #4 voiced she reported her findings to LPN #2.

Resident #131 was sent to the ER on 10/24/18. The surveyor reviewed ER notes on 11/09/18. A physician note from ER visit summary dated 10/25/18 read in part: "...Per facility staff she was being transferred from bed to chair and her leg became caught. She sustained a distal tibia fracture and anterior shin skin tear. It is unclear why she had a delayed presentation at this time. ..."

The surveyor reviewed physician consult note from ER visit summary dated 10/25/18 at 0423 read in part: "Right Lower Extremity: Mild tenderness to palpation. Distal anterior shin skin tear, no obvious communication with fracture site. Mild swelling to the distal shin. Unable to follow commands to move RLE (right lower extremity) ...
Imaging: X ray right tibia demonstrates a distal extra-articular (occurring outside a joint) tib/fib fracture ...and significant osteopenia (lower than normal bone density) ...
Assessment: ... Patient with significant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 34	F 689		

comorbidities, unlikely a surgical candidate at this time. Given her non-ambulatory status, she will likely benefit most by splint immobilization and local wound care to her anterior shin wound ... Plan: No acute intervention indicated at this time. RLE placed in splint by ED provider ... "

The surveyor obtained facility document on 11/07/18 titled "Policy/Procedure Statement: Resident Handling Program." Under section titled "Providing Assistance During Transfers", section C "Mechanical Lifts" read in part: "1. Full body (FBL) Resident is unable/ unwilling to bear any weight on feet, is obese, or unable to follow commands secondary to poor cognition, and weight does not exceed the total weight capacity of the mechanical lift ....Note: Mechanical lifts requires the use of 2 staff members at all times that are trained in transfer of Residents ...."

The surveyor obtained facility document on 11/07/18 titled "Correction Report", under the section titled "Conclusion" read in part: ....After the investigation was completed, it was determined that the fractures were likely caused by CNA #1's improper lift transfer and her failure to ensure the Resident's lower extremities were properly supported and aligned during the transfer ...."

The administrative team was made aware of the above findings on 11/09/18 at 9:10 am.

No further information regarding this issue was provided to the survey team prior to the exit conference on 11/09/18.

*** This is a complaint deficiency ***
2. The facility staff failed to do a smoking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35	F 689		

assessment on Resident #124.

The clinical record of Resident #124 was reviewed 11/7/18 through 11/9/18. Resident #124 was admitted to the facility 9/29/18 with diagnoses that included but not limited to acute respiratory failure, asthma, end stage renal disease, dependence on renal dialysis, internal cardiac defibrillator, type 2 diabetes mellitus, insomnia, peripheral vascular disease, non-rheumatic mitral insufficiency, chronic osteomyelitis, gangrene, muscle weakness, lack of coordination, acute on chronic combined systolic and diastolic heart failure, major depressive disorder, hyperlipidemia, tachycardia, hypertension, and urinary tract infection.

Resident #124's 30-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/27/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

Resident #124's current comprehensive care plan initiated 10/10/18 and revised on 10/10/18 had the focus area of potential for respiratory status r/t (related to) recent respiratory failure, asthma. Interventions: Administer oxygen as ordered, encourage coughing and deep breathing, administer aerosol medication as ordered, observe for shortness of breath.

The surveyor interviewed Resident #124 on 11/8/18 at 1:02 p.m. The resident was observed sitting at the front entrance, smoking. Resident #124 was observed with cigarettes and a lighter. The resident did not have any type of protective smoking equipment on.

The surveyor reviewed Resident #124's clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 36	F 689		

record and was unable to locate a smoking assessment upon admission to the facility. The nursing admission assessment dated 9/29/18 had been marked that Resident #124 was a non-smoker.

The surveyor informed licensed practical nurse #1 of the above concern on 11/8/18 at 1:05 p.m. L.P.N. #1 reviewed Resident #124's clinical record and stated the smoking assessment done on admission stated "no-not a smoker." L.P.N. #1 stated, "Missed that one."

The surveyor informed the assistant director of nursing (ADON) on 11/9/18 at 11:44 a.m. of the above concern. The ADON stated when Resident #124 was admitted, the resident was a non-smoker. The resident started hanging around with residents who were smokers and started smoking again. The ADON stated she was to blame. When asked if a smoking assessment should be done, the ADON stated yes and placed on the care plan.

The surveyor requested the facility policy on smoking on 11/9/18.

The facility policy titled "Smoking/Vaping Policy" read in part "2. Residents will be assessed for their ability to smoke/vape independently. Assessment will be reviewed by the interdisciplinary team at least quarterly and as the resident's condition or behavior changes that impacts the ability to smoke/vape safely."

The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the chief executive officer of the above concern on 11/8/18 at 2:16 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 37	F 689		

No further information was provided prior to the exit conference on 11/9/18.
3. The facility staff failed to perform an elopement risk assessment prior to Resident #48 being transferred from room located on a locked unit to a room that was located on a non-locked unit in the nursing facility.

Resident #48 readmitted to facility on 10/8/15 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, anxiety disorder, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set with an ARD (Assessment Reference Date) of 8/24/18, coded the resident was having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #48 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally independent on 1 staff member for bathing. In Section E0900 "Wandering-Presence & Frequency" coded the resident as a "2" which represents "Behavior of this type occurred 4-6 days, but less than daily".

During the clinical record review on 11/8 and 11/9/18, the surveyor noted that the resident had been moved from a locked nursing unit to a nursing unit that was not locked. This transfer occurred on 11/2/18 as evidenced by documentation in the clinical record. The surveyor noted a physician order dated for 12/11/15, which stated, "Resident requires secure unit due to poor safety awareness and wandering tendencies." This order was discontinued on 11/2/18. A nursing note was made in the progress note section of the clinical record timed and dated for 11/2/18 at 10:36 am, which stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 38	F 689		

"Rsd (resident) no longer requires the memory care unit due to no longer exit seeking ..." The surveyor reviewed the "Elopement Risk Assessment" dated and timed for 11/8/18 at 9:44 am, which gave Resident #48 a score of "7" with a Category list as "Low".

The surveyor notified the administrative team of the above documented findings on 11/8/18 at approximately 2 pm. The surveyor requested to speak to the unit manager on the secure/locked nursing unit that Resident #48 had been a resident.

The surveyor interviewed unit manager #1 for the West Unit on 11/8/18 at 3:40 pm in the conference room. The surveyor asked unit manager #1 if there was an elopement risk assessment that had been completed on Resident #48 prior to the resident being moved out to a room that was located on a non-secured or locked nursing unit. Unit Manager #1 stated, "We look at each resident to see if they still require the safety of being on a secure unit. We felt that ____ (name of resident) did not require this any longer so she was moved." The surveyor notified the unit manager that the resident was coded on the last MDS, which was on 8/24/18, as "Wandering-Presence & Frequency" coded the resident as a "2" which represents "Behavior of this type occurred 4-6 days, but less than daily". The surveyor requested the copy of the last elopement risk assessment that was performed on this resident prior to the decision of moving this resident to a non-secured nursing unit.

At 4:15 pm, the unit manager #1 returned to the surveyor in the conference room and stated, "The last elopement risk assessment was done on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39 8/24/18. There was not one performed before the resident was moved except for this one. But we did do one this morning and she was a low risk on that assessment." No further information was provided to the surveyor prior to the exit conference on 11/9/18.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		12/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 40 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide the necessary care and services for 2 of 38 residents (Resident #377 and Resident #173) with indwelling Foley catheters. The findings included: 1. The facility staff failed to include the size of the catheter and the balloon in the current catheter orders for Resident #377 and failed to provide a diagnosis for the catheter's use. The clinical record of Resident #377 was reviewed 11/7/18 through 11/9/18. Resident #377 was admitted to the facility 10/23/18 with diagnoses that included but not limited to critical illness myopathy, hypertension, hyperlipidemia, atherosclerotic heart disease, embolism and thrombosis of lower extremity arteries, chronic kidney disease, pleural effusion, major depressive disorder, Vitamin D deficiency, chronic systolic heart failure, hypothyroidism, paroxysmal atrial fibrillation, acute respiratory failure, acute hemorrhagic anemia, type 2 diabetes mellitus, transient ischemic attack, cerebral infarction, and encephalopathy. Resident #377's admission minimum data set (MDS) assessment with an assessment	F 690	F690 BOWEL/BLADDER 1. Corrective Action Resident #377□s orders were changed to include the proper catheter and balloon size and a diagnosis was added to support catheter use on 12/6/18. Resident #173 was discharged on November 16, 2018. 2. Identification of Deficient Practice Residents with indwelling urinary catheters have the potential to be affected. 3. Systemic Changes TRC staff was educated on the indwelling urinary catheter order requirements, including size and diagnosis for use. 4. Monitoring Clinical Coordinator/Designee will conduct an audit of current residents with indwelling urinary catheters to ensure catheter/balloon size and diagnosis documentation requirements in physician orders are met. The Clinical Coordinator/Designee will audit all residents with indwelling urinary catheters to ensure proper catheter/balloon size and diagnosis are present in documentation every week for 4 weeks, every other week for 4 weeks and every month for four months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 41 reference date (ARD) of 10/30/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section H Bladder and Bowel was coded for an indwelling catheter (H0100). Resident #377's current comprehensive care plan initiated on 11/7/18 and revised 11/7/18 identified a focus area for indwelling catheter. Interventions: Change catheter per MD (medical doctor) orders/facility policy. The surveyor observed wound care on 11/9/18 at 9:11 a.m. with the wound care licensed practical nurse #2. Upon completion of the wound care, the surveyor and L.P.N. #2 checked the size of the indwelling Foley catheter. L.P.N. #2 stated the catheter size was 16 Fr (French) with a 10 cc (cubic centimeter) balloon. The surveyor reviewed Resident #377's October 2018/November 2018 physician's orders. The surveyor was unable to locate a physician order that detailed the size of the catheter and balloon for Resident #377's current catheter, how often to change the indwelling Foley catheter or orders, or a diagnosis for the catheter use. The surveyor informed the assistant director of nursing of the above concern on 11/9/18 at 1:00 p.m. and requested the facility policy on care of indwelling catheters. The surveyor reviewed the facility policy on 11/9/18. The policy titled "Nursing Catherization (sic) and Care of Urinary Drainage Tubes" read in part "PROCEDURE: 1. Obtain physicians order for urinary catheterization, including catheter and balloon size and reason for use."	F 690	Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 42	F 690		

The surveyor informed the administrative staff of the above concerns in the end of the day meeting prior to the exit conference on 11/9/18.

No further information was provided prior to the exit conference on 11/9/18.

2. The facility staff failed to include the size of the catheter balloon in the physician orders for Resident #173.

The clinical record of Resident #173 was reviewed 11/7/18 through 11/9/18. Resident #173 was admitted to the facility 10/8/18 with diagnoses that included but not limited to left femur fracture, dysphagia, ventricular tachycardia, urine retention, atherosclerotic heart disease, hypothyroidism, irritable bowel syndrome, benign prostatic hyperplasia (BPH), hypertension, atrial fibrillation, insomnia, constipation, and Vitamin D deficiency.

Resident #173's 14-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/22/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section H Bladder and Bowel assessed the resident with an indwelling catheter in H0100.

Resident #173's current comprehensive care plan had the focus area of indwelling Foley catheter: r/t (related to) retention and BPH Initiated: 10/19/18. Interventions: The resident has 16 Fr (French) Foley catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door.

The October 2018/November 2018 physician's orders were reviewed. Resident #173's had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 43 orders for Foley catheter change every month every evening shift starting on the 8th for 1 day (s) Diagnosis: urinary retention Size 16 Fr. The order did not contain the size of the catheter balloon. The surveyor and certified nursing assistant #1 checked the catheter for the size of the catheter and the balloon size on 11/9/18 at 12:30 p.m. with Resident #173's permission. Certified nursing assistant #1 stated the size on the catheter was 5/15 ml (milliliter). The size of the catheter and the balloon size was also observed by the surveyor as 5/15 ml. No other identifying numbers were found on the catheter. The surveyor informed the assistant director of nursing of the above concern with the catheter size and the physician's orders on 11/9/18 at 1:00 p.m. and requested the facility policy on Foley catheters. The surveyor reviewed the facility policy on 11/9/18. The policy titled "Nursing Catherization (sic) and Care of Urinary Drainage Tubes" read in part "PROCEDURE: 1. Obtain physicians order for urinary catheterization, including catheter and balloon size and reason for use." The surveyor informed the administrative staff of the above concerns in the end of the day meeting prior to the exit conference on 11/9/18. No further information was provided prior to the exit conference on 11/9/18.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		12/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 44 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide oxygen as ordered for 1 of 38 residents (Resident #377). The findings included: The facility staff failed to follow physician orders for the use of oxygen for Resident #377. The clinical record of Resident #377 was reviewed 11/7/18 through 11/9/18. Resident #377 was admitted to the facility 10/23/18 with diagnoses that included but not limited to critical illness myopathy, hypertension, hyperlipidemia, atherosclerotic heart disease, embolism and thrombosis of lower extremity arteries, chronic kidney disease, pleural effusion, major depressive disorder, Vitamin D deficiency, chronic systolic heart failure, hypothyroidism, paroxysmal atrial fibrillation, acute respiratory failure, acute hemorrhagic anemia, type 2 diabetes mellitus, transient ischemic attack, cerebral infarction, and encephalopathy. Resident #377's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/30/18 assessed the	F 695	F695: RESPIRATORY/TRACHEOSTOMY CARE 1. Corrective Action Resident #377 will be administered oxygen per physician order. Physician was notified that Oxygen was not administered as ordered on November 9, 2018. Resident #377 did not experience any adverse reactions from deficient practice. 2. Identification of Deficient Practice Residents with orders for continuous oxygen administration have the potential to be affected. 3. Systemic Changes TRC staff was educated on the Oxygen policy. 4. Monitoring Clinical Coordinator/Designee will audit residents with physician ordered continuous oxygen to ensure that O2 is on the resident every week for 4 weeks, every other week for 4 weeks and every month for four months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 45 resident with a BIMS (brief interview for mental status) as 15/15. Resident #377's current comprehensive care plan initiated on 11/7/18 and revised 11/7/18 identified a focus area for potential for impaired respiratory status r/t (related to) recent pleural effusion & respiratory failure. Interventions: Administer oxygen as ordered-see EMR (electronic medical records) for specifics. Resident #377's October 2018/November 2018 physician's orders read "O2 (oxygen) @ (at) 2LPM (liters per minute) via NC (nasal cannula) every shift. Order date 10/23/18 Start date 10/24/18." The surveyor interviewed Resident #377 on 11/8/18 at 9:46 a.m. Resident #377 was in bed and watching television. The surveyor observed an oxygen concentrator in the room but the concentrator was not in use. The surveyor observed wound care on 11/9/18 at 9:11 a.m. with licensed practical nurse #2 doing the wound care. Resident #377 was in bed. Oxygen concentrator was near nightstand but currently not in use. The surveyor observed Resident #377 on 11/9/18 at 11:30 a.m. in the rehabilitation room with rehab staff. Again, Resident #377 did not have oxygen in use. The surveyor informed the assistant director of nursing of the above concern on 11/9/18 at 11:42 a.m. and requested the facility policy on respiratory care.	F 695	5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 46 The surveyor reviewed the facility policy titled "Respiratory Care: Oxygen" on 11/9/18. The policy read in part "PROCEDURE: 1. Obtain doctor's order indicating use of concentrator and the flow rate." The surveyor informed the administrative staff of the above concern during the end of day meeting prior to the exit conference on 11/9/18. No further information was provided prior to the exit conference on 11/9/18.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to store,	F 812	F812: FOOD PROCUREMENT/STORAGE/PREPARAT	12/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENTER	3615 WEST MAIN STREET SALEM, VA 24153

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F 812	Continued From page 47 prepare, distribute and serve food in accordance with professional standards for food service safety in both of the facility's kitchens. The findings included: 1. The facility staff failed to ensure beard restraints covered both the beard and mustache. The surveyor toured the rehabilitation kitchen area on 11/7/18 at 11:59 a.m. with the acting chef. During the tour, the surveyor observed dietary aide (other #2) on the tray line. Other #2 had a beard restraint that covered the beard; however, other #2 also had a mustache. The mustache was not covered by the beard restraint. Also during the initial tour of the rehab kitchen, the acting chef also was observed with a mustache. The mustache was not covered with a beard restraint. The acting chef stated that he would shave the mustache off if a beard restraint was needed. The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the chief executive officer of the above concern on 11/8/18 at 2:39 p.m. The surveyor requested the facility policy on dress code for the kitchen. The surveyor reviewed the facility policy on dress codes for food service workers on 11/9/18. The policy read in part "Wear the approved hair restraint when on duty. Facial hair must be effectively restrained as per local and state regulations. Mustache and/or sideburns must be neatly trimmed. Mustache should not extend below the corners of the mouth; sideburns should not grow beyond the earlobe."	F 812	ION Section 1 1. Corrective Action No residents were affected by the deficient practice. 2. Identification of Deficient Practice The deficient practice was corrected being time of survey. Mustaches, and beard covers were restrained. All residents have the potential to be affected. 3. Systemic Changes A complete review of the Uniform Dress Code Policy was completed. It was determined that the policy failed to adequately reflect exacting expectations in regards to facial hair restraints. The Uniform Dress Code Policy #E006R was revised to include more exacting detail as to facial hair. Dining Service staff have been updated and in-serviced on the policy, process and procedure. 4. Monitoring Employees will be monitored on a daily basis for adherence to the policy. Failure to comply will result in progressive counseling. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Dining Services Section 2 1. Corrective Action No residents were affected by the deficient practice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

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F 812	Continued From page 48 No further information was provided prior to the exit conference on 11/9/18. 2. The facility staff failed to label and date food stored in the hot box storage and failed to maintain equipment in the facility kitchen in proper working condition. On 11/7/18 at approximately 11:15 am, the surveyor observed in the main freezer that the condenser had frost and ice build-up noted on it. Facility Employee #1 stated, "I just help out in the kitchen at lunch right now until we get a full time manager but I will let the administrator know about this concern." On 11/8/18 at approximately 9:20 am, the surveyor observed the following in the facility kitchen: 1. The steamer had steam and water around both doors and there was a puddle of water in the floor. 2. In the "Hot Box" holding area, there were 24 bowls of oatmeal and 4 trays that contained scrambled eggs bacon and biscuits. The items were not labeled or dated. Dietary Aide #1 stated, "I put them in there after breakfast this morning. I did that so that if anyone called down for a late breakfast, I would have it to give to them. I will throw this all away right now." The surveyor notified the administrative team on 11/8/18 at approximately 2 pm in the conference room. The surveyor requested a copy of the facility's policy concerning food storage. At 4 pm, the administrator provided the surveyor with a copy of the work order for the above	F 812	2. Identification of Deficient Practice The deficient practices were corrected at time of survey. Food being held in hot holding was discarded. Freezer was serviced; ice build-up was removed. Steamer was serviced repairing damaged door which was cause of escaping steam and water puddling. All residents have the potential to be affected. 3. Systemic Changes A complete review of the relevant facility policies was conducted. It was determined that not all relevant material was provided at time of survey. It was also determined that revisions and modifications to related policies and procedures were required. Revisions and updates to policy #B003R-Food and Supply Storage, and #G006 were completed. Dining Service staff have been updated and in-serviced on the policies, processes and procedure. 4. Monitoring Monitoring checklist and logs provided in policies #G006 and #B003R utilized per policy.. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Dining Services	

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F 812	Continued From page 49 documented findings. On this copy, the surveyor noted the following documentation, which read in part, " ...I found a gap at the top corner of the door adjusted the hinges to close the gap ..." The administrator also stated, "We are having someone to come in and look at the compressor in the main freezer." The surveyor reviewed the facility's policy titled "Production, Purchasing, Storage" at 4:30 pm which read in part, " ...Cover, label and date unused portions ..." No further information was provided to the surveyor prior to the exit conference on 11/9/18.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		12/24/18

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F 842	Continued From page 50 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 51 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview it was determined the facility staff failed to keep complete and accurate clinical records for 1 of 38 residents (Resident #162.) Findings: 1. Resident #162 was admitted to the facility on 2/13/13. He had diagnoses which included hypertension, anemai, diabetes, quadriplegia and traumatic brain injury. The latest MDS (minimum data set) assessment, dated 10/17/18 coded the resident with some cognitive impairment. The resident was still acting as his own responsible party for decision making regarding his care. He required total assistance for all the ADLS (activities of daily living). Resident #162's physician's orders, signed and dated on 10/11/18, included the order for a "Full CODE." The resident's clinical record contained an advance directive, signed and dated by the resident on 9/25/95, which included a DNR (do not resusitate) request. This documentation represented a conflict as to whether or not the resident was to be a full code or a DNR. This issue was discussed on 11/9/18 at 10:40 AM with the facility DON. She said she had	F 842	F842: RESIDENT RECORDS 1. Corrective Action Resident #162□s advance directive was removed from his chart to reflect his wishes to have Full Code status on 12/10/18. 2. Identification of Deficient Practice Residents with advance directives have the potential to be affected. 3. Systemic Changes A) Social Workers will be re-educated regarding the importance of accurate clinical records regarding residents□ code status. 4. Monitoring Medical Records Coordinator/Designee will audit resident charts to ensure that residents with a Full Code status do not have Advance Directives reflecting otherwise on record. Social Worker will audit code status in EMR during care plan meetings and ensure that Advance Directives reflecting alternate code status directives are not present in medical record weekly x 6 months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018	

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F 842	Continued From page 52 clarified that the resident had changed his DNR status to a full code during a recent hospitalization and the advance directive should come out of his record to ensure his wishes were carries out correctly. No other information was provided prior to the survey exit.	F 842	6. Title of Person Responsible for Implementation: Director of Social Services.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and during the course of a quality assurance review, and during a complaint investigation, it was determined the facility staff failed to identify and develop action plans to address quality of care issues for resident handling and transfers. The findings include: As a part of the survey process the survey team identified quality of care concerns in the area of resident handling and transfers. During a complaint investigation it was determined the staff failed to follow appropriate transfer policies that resulted in a serious harm level injury to one resident (# 131.) This incident occurred on 10/20/18. On 11/09/18 at 11:14 AM the survey team met	F 867	F867: QAPI/QAA 1. Corrective Action An action plan was developed to address quality of care issues for resident handling and transfers on November 9, 2018 2. Identification of Deficient Practice Care issues regarding non-compliance with resident handling policies that may require action plan development have the potential to be affected. 3. Systemic Changes Newly identified resident handling concerns will be present to and evaluated by the Quality Assurance committee for potential action plan development during QA meetings. 4. Monitoring Results of the observations will be reported to the QAPI Committee for	12/24/18

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F 867	Continued From page 53 with the facility DON to discuss the QA (quality assurance) program. The DON was the spokesman for the QA committee. The surveyor and the DON discussed how the QA committee met monthly and who the committee members were. The DON said the issues were identified by several different routes. The daily staffing meetings, resident council and direct care staff were used to identify new areas of concern. During the discussion of the issues the QA committee had identified and addressed over the past year, it was determined the DON had received information pertaining to inappropriate transfers of residents by staff members during August of 2018. The DON said a staff member had approached her and informed her of other staff members who were not doing transfers appropriately with residents. The DON said the information was provided that all transfers, including those utilizing gait belts and lifts, were included during the fact finding and educational process. The DON said this information was used to educate the staff on appropriate resident handling and transfer methods during mandatory inservices on 8/7, 8, 9, 11 & 14/18. These mandatory inservices were reviewed and it was determined that only 37 CNAs out of approximately 100 employed by the facility had attended the inservices to correct the transfers and resident handling methods. The DON said she was not sure if she had taken the issue to the QA committee or not, but she	F 867	review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing	

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F 867	Continued From page 54 would check. On 11/9/18 at 2:05 PM the administrator, DON and CN I (corporate nurse) were asked if the matter had been brought before the QA committee and an action plan developed. The CN I said the issue had not been addressed by the QA committee. "There's nothing found on that. We should have put an action plan in place." After this discussion, the DON said she would say additional education was required and the issue was going to go through the QA committee to determine the next steps. "I'll look at the education in August 2018 and decide whether to do another resident handling review and bring it through QA and let them determine what they want to do as far as education and monitoring and ensuring staff are following policy by random lift observations--to make sure the staff are following policy." No additional details were provided prior to the survey team exit. Please refer to F- 689 for additional details on the quality of care issue for accidents and transfers/resident handling.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		12/24/18

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F 880	Continued From page 55 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 56 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control guidelines during wound care that affected two of 38 residents (Resident #377 and Resident #203). The findings included: 1. The facility staff failed to clean the lanyard on which the scissors used in wound care were attached for Resident #377. The wound care licensed practical nurse #2 brought the treatment cart into Resident #377's room during wound care and did not clean the cart upon finishing the wound care and leaving the room. L.P.N. #2's wound care was not observed from the center outward and in a circular manner. The clinical record of Resident #377 was	F 880	F880: INFECTION PREVENTION & CONTROL 1. Corrective Action Resident #377 and #203 did not appear to be negatively affected by deficient practice. Residents□ physicians were notified on November 9, 2018. 2. Identification of Deficient Practice Residents requiring wound cleansing and dressing changes have the potential to be affected. 3. Systemic Changes A) The Wound/Dressing Change and Infection Control Policies were reviewed. B) Wound Care Coordinator has been re-educated regarding proper wound care treatment procedure. C) Staff Development Coordinator/Designee will conduct	

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F 880	Continued From page 57 reviewed 11/7/18 through 11/9/18. Resident #377 was admitted to the facility 10/23/18 with diagnoses that included but not limited to critical illness myopathy, hypertension, hyperlipidemia, atherosclerotic heart disease, embolism and thrombosis of lower extremity arteries, chronic kidney disease, pleural effusion, major depressive disorder, Vitamin D deficiency, chronic systolic heart failure, hypothyroidism, paroxysmal atrial fibrillation, acute respiratory failure, acute hemorrhagic anemia, type 2 diabetes mellitus, transient ischemic attack, cerebral infarction, and encephalopathy. Resident #377's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/30/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #377's current comprehensive care plan identified Resident #377 to have potential for/impaired skin integrity r/t (related to) atherosclerotic heart disease, hyperlipidemia, ASA therapy, neuropathy, O2 (oxygen) dependent. CHF (congestive heart failure), muscle weakness, Vit (Vitamin) D deficiency, depression, thrombosis of the lower extremity, CKD3 (chronic kidney disease-stage 3), hypothyroidism, A fib (atrial fibrillation), DM (diabetes mellitus)-10/23/18 Right heel unstageable, unstageable to the sacrum, right buttock stage 2-resolved 11/6/18. Interventions: Administer treatments as ordered. The surveyor reviewed Resident #377's October 2018/November 2018 physician's orders for wound care. Cleanse sacrum unstageable wound with NS (normal saline) and pat dry. Apply	F 880	random wound care treatment audits every week for 4 weeks, every other week for 4 weeks and every month for four months to ensure compliance. 4. Monitoring Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: December 24, 2018 6. Title of Person Responsible for Implementation: Director of Nursing.	

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F 880	Continued From page 58	F 880		

skin prep to surrounding peri wound skin and allow to dry. Apply silver alginate and a optifoam 4 x 4 dressing bid (twice a day). Start date: 11/6/18. Silvadene cream 1% Apply to right heel topically every day for right heel unstageable. Cleanse right heel with NS and pat dry. Apply silvadene and dry dressing daily-wound healing. Start date: 11/7/18.

The surveyor observed wound care on 11/9/18 at 9:11 a.m. with licensed practical nurse #2. L.P.N. #2 knocked on door, checked the resident's pain level. L.P.N. #2 washed hands and then cleaned the over the bed table with Sani-Cloths. L.P.N. #2 placed a barrier on the table and washed hands. Gloves were donned. L.P.N. #2 dated bandage prior to applying. Removed gloves and left room to get treatment cart. L.P.N. #2 brought treatment cart into resident's room. L.P.N. #2 removed sterile water and gauze from the treatment cart and placed them on the barrier. Gloves on. Cleaned scissors with Sani-cloth but not the lanyard and placed both the scissors and the lanyard on the barrier. Locked cart. Removed gloves. L.P.N. #2 dated sterile water, washed hands, and donned gloves. The head of bed was lowered. Resident #377 was turned on left side. Right heel sock removed and placed on bed. Old dressing removed and discarded. L.P.N. #2 removed gloves and washed hands. L.P.N. #2 donned gloves. Right heel has quarter size unstageable dark area-eschar. Area cleaned with sterile water numerous times. L.P.N. #2 removed gloves and hands were washed. L.P.N. #2 donned gloves. Silvadene cream applied to area and wrapped with kerlix. Dated tape applied. L.P.N. #2 removed gloves and washed hands. Donned gloves then took gloves off. L.P.N. #2 went to treatment cart and got a bottle

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 59	F 880		

of Normal Saline. L.P.N. #2 donned gloves. The unstageable pressure area on sacrum is elongated and approximately 2 and 1/2 inches by 1 inch and a second one approximately nickel size. L.P.N. #2 cleaned both areas at the same time with normal saline gauze. L.P.N. #2 did not use a circular fashion starting from the center of the area and working outwards. L.P.N. #2 applied skin prep to perimeter of wound, then silver alginate and optifoam dressing was applied. L.P.N. #2 removed gloves and washed hands. Donned a new pair of gloves. L.P.N. #2 cleaned the area surrounding the wound with foam cleanser. L.P.N. #2 removed gloves and washed hands. L.P.N. #2 donned new gloves. Greer's goo applied to area that was reddened. L.P.N. #2 removed gloves and washed hands. L.P.N. #2 donned gloves and repositioned the resident. Green heel boot applied to right leg. All supplies removed and discarded. Table cleaned with Sani-cloth and scissors cleaned with Sani-Cloth but not the lanyard. Trash removed.

The order for wound care to the right heel read to use normal saline. L.P.N. #2 did not follow the physician order. Sterile water was used. L.P.N. #2 did not use circular motion to cleanse the wound from the center of the wound outward. L.P.N. #2 failed to clean the lanyard that was attached to the scissors before placing both on the barrier and L.P.N. #2 brought the treatment cart into the resident's room. The treatment cart was not cleaned after L.P.N. #2 removed the cart from Resident #377's room.

The surveyor informed the director of nursing of the above concern on 11/09/18 1:27 p.m. and requested the facility policy on infection control.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 11/09/2018

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F 880	Continued From page 60	F 880		

The surveyor reviewed the facility policy on infection control titled "Infection Control Guidelines for All Nursing Procedures" on 11/9/18. The policy read in part "5. b. Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed and single use items are properly discarded."

No further information was provided prior to the exit conference on 11/9/18.

2. The wound care nurse performed wound care to Resident #203. During the wound care observation, the wound care nurse cleaned her scissors but did not clean the lanyard that was attached to the scissors and cleaned the sacral wound with 4x4's but did not use a circular motion in cleaning of this wound.

Resident #203 was admitted to the facility on 2/8/12 with the following diagnoses of, but not limited to high blood pressure, dementia, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/22/18, the resident was coded as having short term and long-term memory loss and being severely impaired in making daily decisions. Resident #203 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

On 11/8/18 at 10:40 am, the surveyor was observing wound care being performed on Resident #203 by the wound care nurse. During this observation, the surveyor noted the surveyor noted the following that the wound care nurse performed:

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F 880	Continued From page 61	F 880		

The wound care nurse prepared her work area on the resident's bedside table. The table was cleaned with a disinfectant wipe and then a drape was placed on it. The nurse laid the clean supplies that would be used for the wound care on the drape. The wound care nurse cleaned her scissors but the lanyard that was attached to the scissors was not cleaned. The nurse laid the scissors with the lanyard attached on the clean drape beside of the clean supplies that the nurse would use for the wound care to the resident. The resident had 2 open areas on the outer aspect of the right foot that the physician ordered them to have skin prep applied and then wrapped with Kerlix. The wound care nurse cleaned these areas with normal saline that was applied to clean 4x4's. The wound care nurse used the same 4x4's to clean both open areas to the outer aspect of the right foot. The nurse cleaned the opens areas using a circular motion but went back over the open areas again with using the same 4x4. While the wound care nurse waited for the skin prep to dry on these areas, the nurse blew on the areas so that drying could be faster. The wound care nurse completed the wound care to the outer aspect of the right foot. The wound care nurse then removed her gloves and washed her hands. The nurse reapplied gloves and removed the old dressing that was on the resident's sacrum area. The nurse removed her gloves and washed her hands. The wound care nurse reapplied clean gloves to her hands. The nurse began to clean the sacral wound with normal saline that had been applied to clean 4x4's. The wound care nurse began cleaning the wound by wiping the 4x4's over the wound and continued to clean the wound by wiping all areas of the wound but

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F 880	Continued From page 62	F 880		

not in a circular motion. The nurse continued wound care to the sacral wound as prescribed by the physician.

On 11/8/18 at approximately 1 pm, the surveyor requested and received a copy of the policy titled, "Wound Cleansing and Dressing Changes". It read in part, " ...10. Gently cleanse the wound with normal saline (unless order specifies differently), starting in the center of the wound and working outward in a circular motion ...Repeat with another clean gauze as needed until the entire wound surface is cleaned ..."

The surveyor notified the administrative team of the above documented findings on 11/9/18 at approximately 2 pm.

No further information was provided to the surveyor prior to the exit conference on 11/9/18.